Date: May 10, 1999 DSL-BQA-99-027

To: Home Health Agencies HHA 13

From: Rita Prigioni, Interim Director
Bureau of Quality Assurance

Outcome ASsessment Information Data Set (OASIS) Update
Memo # 7

The purpose of this memorandum is to provide further information related to the federal Outcome ASsessment Information Data Set (OASIS).

ALERT: Delay in mandatory collection, use, encoding and transmission of OASIS

Effective April 27,1999, the Bureau of Quality Assurance was notified that mandatory collection, encoding and transmission of OASIS data has been delayed. During the delay in implementation, home health agencies that are not meeting the effective dates for collection, encoding and transmission will not be held out of compliance. We have attached a copy of the HCFA alert for your reference. This notice has been posted on the HCFA website. A Federal Register notice was also published May 4, 1999, reiterating the delay. There should be a link on the OASIS website to the Federal Register notice by the time you receive this memorandum.

HCFA anticipates that agreement can be reached on the contents of the OASIS related regulations by the end of May. A Federal Register notice will be published shortly after all clearances have been approved. The new effective date will be determined by the date of the Federal Register publication. There will be no retroactive expectations. HCFA expects collection and encoding to happen right away with transmission following about a month later.

Amended Data Specifications

The Health Care Financing Administration recently released amendments to the Version 1.03 OASIS-B1 data specifications. These changes tighten the criteria for rejection of OASIS assessment records that do not meet certain specifications and were implemented on the state system when new system software was installed in April 1999. A document describing the changes has been posted on the Bulletins page of the OASIS system (accessible to all home health agencies using their standard User ID and password). This document lists the current and enhanced record rejection criteria and the error messages that will be generated when these specifications are not met. The changes can also be viewed on the IFMC website at www.ifmc.org/stso (go to OASIS documentation in the download zone).

OASIS Questions and Responses

The Bureau of Quality Assurance has received many OASIS questions that are the same or similar. For clarity reasons, we will not repeat similar or duplicative questions and responses within this

memorandum. Refer to BQA Memo 99-018 for additional questions and responses distributed prior to this memorandum.

Due to the HCFA announcement delaying OASIS implementation, the specific time points for data collection, encoding and transmission are no longer effective. The following questions have been responded to taking this information into consideration.

Question: What if a patient refuses to provide OASIS information to the provider or refuses to have the provider transmit the information to the state agency or HCFA?

The incorporation of OASIS data into the Condition of Participation for the patient comprehensive assessment is considered the **standard of practice** for home health agencies choosing to participate in the Medicare program. OASIS data items have been collected in the past in one form or another by virtually all home health agencies when conducting a thorough patient assessment. The OASIS items should be answered as a result of the clinician's total assessment, not administered as a structured interview. Conducting the assessment involves both interaction (interview) and observation. These two processes should compliment each other. If your agency is having difficulty with specific OASIS items, you should consider reviewing with your staff the processes of performing a comprehensive assessment. Such difficulties may indicate that clinical staff may need additional training in assessment skills. If required by federal law, data collection and transmission will be considered a Condition of Participation in the Medicare program.

Question: The registered nurse conducted a routine visit for a patient on March 4. The home health aide visited the patient on March 5 and March 6. On March 7, the physician called the agency and unexpectedly discontinued home care. What OASIS data are reported in MOO90 – date of assessment, MO100 – reason for assessment, and MO906 – discharge/transfer/death date?

The nurse would complete the OASIS data requested for discharge, at data item MO100 (Reason for assessment), code a 9, agency discharge. The information on the patient's status on the most recent visit by a qualified clinician (March 4) is used to complete the discharge assessment. The date the assessment is completed (MOO90) would be March 7, the day the agency learned of the discharge. Code data item MO906 – discharge/transfer/death date as March 7.

Question: What does the agency do when they learn that the patient was hospitalized for over 24 hours? Sometimes we do not learn about this until the next visit.

If the agency learns of a hospitalization stay of more than 24 hours, the clinician completes the Transfer to Inpatient Facility form (with or without agency discharge according to your agency policy). Code MOO90 – Date Assessment Completed, with the date you learned of the hospitalization. Code MO906 – Discharge/transfer/death, with the date the patient was transferred to the inpatient facility. The date of post-hospitalization visit would be the resumption of care or new start of care date, depending on your agency policy for discharge.

Question: Our agency does not discharge patients until after 48 hours. Must we complete a resumption of care assessment if the patient is discharged from the hospital after a 26-hour stay?

Yes, if a patient is admitted to an inpatient facility for more than 24 hours the transfer to inpatient facility is reported. The clinician would use response 7 for MO100 to indicate the reason for the assessment. When the patient returns home the clinician would report resumption of care data. For MO100, the clinician would select response 3 to indicate the assessment is being completed for resumption of care following an inpatient stay.

Question: Are medication changes included when responding to data item MO200, Medical or Treatment Regimen change within past 14 days?

Yes, this data item identifies any changes in the patient's treatment regimen, health care services or medications due to a new diagnosis or exacerbation of an old diagnosis within the past 14 days. The 14 days encompasses the two-week period immediately preceding the date of the assessment (start of care, resumption of care, follow-up or discharge). This information can be obtained from the patient, caregiver or physician.

Question: If a patient is admitted and discharged on the same visit, does the agency complete both the start of care assessment and discharge assessment?

No. If the clinician makes the start of care visit and determines that the initial visit is the only visit to be made, they would code a "2" (start of care, no further visits planned) at MO100. A subsequent discharge assessment is NOT required. The information regarding this patient will be captured on the home health agency's case mix report but not on an outcome report, as two time points are not available for analysis.

Question: What assessment needs to be completed for a change in the patient's primary pay source during an episode of care? For example, the pay source changes from Medicare to an alternate pay source or visa versa.

If the original start of care date were maintained, you would continue assessments and OASIS data collection and reporting according to that date. A new pay source is reported (or deleted if no longer applicable) at MO150 – Current Pay Sources for Home Care at the next regular assessment.

If the start of care date changes to coincide with a pay source change, discharge the patient from this episode of care for OASIS purposes. The discharge date for the Discharge OASIS data collection, would coincide with the last visit of "old" pay source. A new initial comprehensive assessment would need to be completed with the new start of care date. The OASIS Implementation Manual, chapter 8, page 8.6 describes this situation in detail.

Question: ***How can home health agencies fulfilling the requirement for OASIS data collection every second calendar month (within the 5-day window), and have a signed plan of care for the beginning of a new certification period?***

State licensure rules and federal Medicare regulations require that a home health agency have physician orders for home health services to continue home health services into the next certification period. This requirement should not be confused with the requirement for OASIS data collection.

Three things remain constant for home health agencies: 1) the agency must have physician orders to provide services in a new certification period (whether they are verbal or written), 2) the comprehensive assessment for **OASIS must** occur in the last 5 days of every second calendar month based on the start of care date, and 3) the plan of care **must** reflect the patient's current condition and interventions (meaning that the patient's status and plan of care are in sync).

Agencies need to consider that completing a recertification plan of care weeks in advance based on the patient's status at that time and then completing the comprehensive assessment within the last 5 days of the certification period may be problematic if the clinician notes a change in the patient's condition from the earlier assessment and plan of care development that no longer substantiates that plan. For example, the patient's condition has deteriorated meaning that new interventions are needed. The agency would

need to contact the physician and obtain a verbal order to modify the plan of care reflecting the patient's current condition and interventions.

The Conditions of Participation do not require that the plan of care is signed and in the medical record by the time the new certification period begins.

Agencies can continue the practice of obtaining a signed plan of care prior to the end of the certification period. Or agencies have the option to contact the physician, indicate the patient status, indicate the rationale for re-certification, review the plan of care with the physician and subsequently obtain and document receipt of a verbal order (including visit frequency and plans).

Agency policy determines where and how the clinician documents verbal orders. For example: whether the clinician immediately records and signs the verbal order on a verbal order sheet or at locator 23 on the HCFA 485 form. To remain in compliance with HSS 133.20 (4), Physician's orders, the agency is required to obtain the physician's countersignature on verbal orders within 10 days.

Question: Does the follow up data collection time point reference the start-of-care (SOC) date of 10/1/98 or will it reference the new certification date of 10/16/98?

The follow up data collection would be completed within the last 5 days of every second calendar month based on the SOC date.

Question: The patient's OASIS 5-day window is 11/24-11/29. Normally a visit would take place on 11/23 for every 14-day supervisory and skilled nurse visit. What should we do?

The home health agency must complete the 14-day supervisory visit at least every 14 days per CFR 484.36(c). Supervisory visits can be completed sooner, but no later than 14 days from the previous supervisory visit. In this example, the agency would have to make two separate visits.

Question: For M0360, does answer number 0 (no one person) mean <u>no one</u>, or not only one?

The response zero means there is "no one person" considered as the primary caregiver.

Question: Do the discharge questions have to be completed on the day the discharge is received? If we see a patient on one day and two days later receive the discharge order, do we have to go back and make another visit to complete the OASIS discharge questions?

The discharge OASIS assessment must be completed within 2 calendar days of the discharge. When the patient is discharged from the agency another home visit is <u>not</u> necessary. The OASIS data collection would be based on the last skilled home visit prior to discharge. The discharge date would be the date the physician called to discontinue services.

Question: If an extra visit is made to complete OASIS information, is this visit a chargeable visit to Medicare?

If an additional visit is made to conduct a comprehensive assessment inclusive of the OASIS data elements, this visit may not be a Medicare covered visit.

Question: Do we need to do start of care questions on all patients who are already on services?

Due to the notice delaying OASIS implementation, home health agencies will be required to collect start of care information on all patients admitted to the agency on or after the new effective date when established by HCFA.

Question: Do the OASIS questions have to be asked of patients regardless of what they are admitted for? We admit some patients for focused needs such as administering insulin to children while the parents are gone on vacation.

Yes, you must complete OASIS for anyone admitted to a Medicare certified agency except individuals under 18, maternity patients and those receiving supportive home care (chore) services.

Question: Do we need to complete the transfer to inpatient facility questions if a patient is in the hospital on a 23 hour stay and is not discharged from homecare?

No, complete the transfer to inpatient facility only if the patient is admitted to the inpatient facility for **over** 24 hours.

Question: What is the definition of maternity?

Webster's dictionary defines maternity as the "condition of motherhood". This is an acceptable definition.

Question: We do home care visits on post-partum women for instruction on breastfeeding? Do we need to complete OASIS questions on these patients?

No.

Question: What if we see a pregnant woman for a reason other than obstetrical assessment?

Yes, OASIS data collection would apply, as you would be treating the non-obstetrical reason for admission to the agency.

Question: Can a physical therapy assistant complete the discharge assessment or must it be a physical therapist.

The discharge assessment must be completed by physical therapist. A physical therapist assistant cannot complete a discharge assessment (refer to Implementation Manual, Chapter 4, page 4.5 and MOO80).

Question: When asked to list medical diagnoses for which home care is seeing patient, do we include diagnoses for which we are doing only minimal teaching or monitoring, i.e., patient is being seen for a wound, but we ask what the blood sugar is or remind patient of importance of eating low sugar diet?

Yes, the number of diagnoses is not limited. MO230/240 require that each medical diagnosis or problem be listed for which the person is receiving home care.

Question: Does an OASIS form need to be completed at the time of Medicare denial if the patient is not discharged?

No.

Question: If a patient is discharged by phone, is the discharge form or the transfer form used? If the discharge form is used, does a non-charged visit need to be made to complete the assessment?

No, a non-charged visit does not need to be made to complete the assessment. However, the discharge OASIS items must be completed. The agency should complete this data collection based on the last skilled home visit.

Question: If the patient expires, prior to a home visit, how is the discharge form completed?

The discharge data items would be completed based on information available from the family, caregivers or the inpatient facility (MO100 response #7). A telephone call should provide the information necessary to complete the data items.

Question: If the patient expires, is the date of assessment the date of death?

The date recorded at MOO90 would be the date the agency completed the assessment; this could be the same date as date of death or the date the agency received the information.

Question: Do all MOO items need to be placed on the medical record if the patient is discharge due to death?

The agency would complete only the OASIS items related to death (refer to the OASIS Implementation manual, Appendix A, Comparison between start of care, follow-up, transfer and discharge versions of the OASIS B-1). The agency's medical record policy should provide specific direction if the assessment should be maintained in an electronic or hard copy medical record system. If the information is maintained electronically, the system must have the capability to print the record upon request.

Question: If skilled nursing and physical therapy are both seeing a client, can the skilled nurse complete the discharge OASIS even though physical therapy is the last visit made to the client, i.e., skilled nurse's last visit is a week or two prior to last physical therapy visit?

The discharge OASIS data elements should be collected by the last skilled service seeing the patient. In this example, the discharge OASIS assessment should be completed by the physical therapist. If your agency policy requires the nurse to complete the OASIS assessment at discharge, another visit would be required.

Question: Skin burns are not considered pressure ulcers and they are not stasis ulcers, how are they coded?

The agency would answer MO440, yes, MO445 would be no, then skip to MO468 which would be no, then skip to MO482 which would be no, then skip to MO490.

Question: When physical therapy is the only skilled service in the home and the therapist does not get a follow-up or discharge OASIS completed before leaving on a vacation, can the skilled nurse complete the OASIS so it is not late?

Yes, a RN can complete the OASIS. This would have to be described/clarified within your agency policies/procedures.

Question: What is the state's plan to change their regulations/rules that are in conflict with the OASIS Conditions of Participation and HSS 133 (i.e., 72 hours to develop POC (485) and Conditions of Participation and OASIS allowing 5 days to complete the comprehensive assessment (including OASIS data elements)?

The Bureau of Quality Assurance will evaluate this recommendation in future revisions of the Wisconsin Administrative Code HSS 133 related to plan of care development.

Can Occupational Therapy do the start of care assessments?

For purposes of Medicare, the occupational therapist cannot do the start of care assessment.

Question: If a pressure ulcer is currently healed, but had been problematic earlier, how would we answer M0440? If we say there is no lesion/wound, then there would be no need to answer M0450.

If the clinician responds no to MO490 (does the patient have a skin lesion or an open wound), the skip pattern would direct them to MO490 (related to shortness of breath). You are correct; there would be no need to answer MO450.

Question: When submitting our assessments electronically during the test period, we received error messages 14 and 15 on our feedback report that say the Medicare and Medicaid numbers don't match the state database. Do we need to do anything?

No. You received these error messages because the state hasn't entered these numbers in the agency database yet. Once the numbers are entered in the database you won't receive these error messages anymore. You should not change your numbers or remove them from your header record.

Please direct any questions you may have regarding OASIS data collection to Barbara Woodford, OASIS Educational Coordinator, at (608) 264-9896. Questions related to software and data transmission should be directed to Richard Betz, OASIS Automation Coordinator, at (608) 264-9898.

Attachment